		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036095

Facility Name: Lexington of Schaumburg

Address: 635 S. Roselle Rd. (Number) Schaumburg (City) 60193 (Zip Code)

County: Cook

Telephone Number: (847) 351-5500 **Fax #** (847) 352-8592

IDPA ID Number: 363678108001

Date of Initial License for Current Owners: 3/3/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	224	Skilled (SNF)	224	81,984	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	224	TOTALS	224	81,984	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	47,648	6,352	8,033	62,033	8
9	SNF/PED					9
10	ICF	10,309	2,500	96	12,905	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	57,957	8,852	8,129	74,938	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.41%

D. How many bed-hold days during this year were paid by Public Aid?
467 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 4/1/90

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [x] New construction

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 34 and days of care provided 5,643

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7 **	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	300,953	33,415	14,049	348,417		348,417		348,417			1
2	Food Purchase		307,501		307,501		307,501	(12,848)	294,653			2
3	Housekeeping	271,985	33,947		305,932		305,932		305,932			3
4	Laundry	51,413	21,676		73,089		73,089	(4,731)	68,358			4
5	Heat and Other Utilities			180,733	180,733		180,733	2,275	183,008			5
6	Maintenance	76,768		113,904	190,672		190,672	4,041	194,713			6
7	Other (specify):*											7
8	**TOTAL General Services**	701,119	396,539	308,686	1,406,344		1,406,344	(11,263)	1,395,081			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	3,015,442	231,880	113,712	3,361,034		3,361,034		3,361,034			10
10a	Therapy			459,452	459,452		459,452		459,452			10a
11	Activities	183,843	18,578	3,450	205,871		205,871	17	205,888			11
12	Social Services	43,943		2,741	46,684		46,684		46,684			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,243,228	250,458	588,355	4,082,041		4,082,041	17	4,082,058			16
	C. General Administration											
17	Administrative	149,841		410,289	560,130		560,130	(410,289)	149,841			17
18	Directors Fees											18
19	Professional Services			84,953	84,953		84,953	(15,192)	69,761			19
20	Dues, Fees, Subscriptions & Promotions			46,789	46,789		46,789	3,914	50,703			20
21	Clerical & General Office Expenses	341,608	33,561	24,079	399,248		399,248	18,157	417,405			21
22	Employee Benefits & Payroll Taxes			556,766	556,766		556,766	57,126	613,892			22
23	Inservice Training & Education							282	282			23
24	Travel and Seminar			2,386	2,386		2,386	516	2,902			24
25	Other Admin. Staff Transportation							8,852	8,852			25
26	Insurance-Prop.Liab.Malpractice			41,484	41,484		41,484	35,642	77,126			26
27	Other (specify):*											27
28	**TOTAL General Administration**	491,449	33,561	1,166,746	1,691,756		1,691,756	(300,992)	1,390,764			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,435,796	680,558	2,063,787	7,180,141		7,180,141	(312,238)	6,867,903			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Lexington of Schaumburg #0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7 **	8	9	10	
	D. Ownership											
30	Depreciation			43,616	43,616		43,616	191,271	234,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							621,697	621,697			32
33	Real Estate Taxes							400,461	400,461			33
34	Rent-Facility & Grounds			1,594,449	1,594,449		1,594,449	(1,594,449)				34
35	Rent-Equipment & Vehicles			1,331	1,331		1,331	385	1,716			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,639,396	1,639,396		1,639,396	(380,635)	1,258,761			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		109,573	20,125	129,698		129,698		129,698			39
40	Barber and Beauty Shops			26,408	26,408		26,408		26,408			40
41	Coffee and Gift Shops			14,500	14,500		14,500		14,500			41
42	Provider Participation Fee			122,976	122,976		122,976		122,976			42
43	Other (specify):* Nonallowable costs			80,317	80,317		80,317	(80,317)				43
44	**TOTAL Special Cost Centers**		109,573	264,326	373,899		373,899	(80,317)	293,582			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,435,796	790,131	3,967,509	9,193,436		9,193,436	(773,190)	8,420,246			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(643)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,731)	4		8
9	Non-Straightline Depreciation	(6,451)	30		9
10	Interest and Other Investment Income	(19,800)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,488)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(400)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(47,437)	43		24
25	Fund Raising, Advertising and Promotional	(7,392)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(24,034)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule A	(20,347)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (132,723)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(640,467)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (640,467)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (773,190)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Lexington of Schaumburg

ID# 0036095

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
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37				37
38				38
39				39
40				40
41				41
42				42
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	0		90

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas	22.33%	See attached Schedule B		Sambell of Schaumburg		
John Samatas	22.33%			Ltd. Ptsp.	Schaumburg	Real estate ptsp.
Cynthia Thiem	22.34%					
Jeffrey Bell, James Bell Declaration of Trust, Larry Bell				Royal Mgmt. Corp.	Lombard	Mgmt. Co.
and David Bell each owning 8.25%	33.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,594,449	Sambell of Schaumburg Limited Partnership	**	$	$ (1,594,449)	1
2	V	30	Depreciation		Sambell of Schaumburg Limited Partnership	**	185,169	185,169	2
3	V	32	Amortization of mortgage costs		Sambell of Schaumburg Limited Partnership	**	17,076	17,076	3
4	V	33	Property taxes		Sambell of Schaumburg Limited Partnership	**	391,271	391,271	4
5	V	26	Insurance		Sambell of Schaumburg Limited Partnership	**	3,177	3,177	5
6	V	43	State replacement tax		Sambell of Schaumburg Limited Partnership	**	34	34	6
7	V	21	Bank charges		Sambell of Schaumburg Limited Partnership	**	250	250	7
8	V	26	Mortgage insurance		Sambell of Schaumburg Limited Partnership	**	30,657	30,657	8
9	V	19	Professional fees		Sambell of Schaumburg Limited Partnership	**	7,690	7,690	9
10	V	32	Interest income		Sambell of Schaumburg Limited Partnership	**	(21,674)	(21,674)	10
11	V	32	Interest expense		Sambell of Schaumburg Limited Partnership	**	644,027	644,027	11
12	V								12
13	V								13
14	Total			$ 1,594,449			$ 1,257,677	$ * (336,772)	14

** The owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Sambell of Schaumburg Limited Partnership.

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	FICA	$	Royal Management Corp.	**	$ 24,170	$ 24,170	15
16	V	22	FUTA		Royal Management Corp.	**	502	502	16
17	V	22	SUTA		Royal Management Corp.	**	1,347	1,347	17
18	V	22	Insurance - W/C		Royal Management Corp.	**	284	284	18
19	V	22	Insurance - Hospitalization		Royal Management Corp.	**	12,224	12,224	19
20	V	22	401 (k) and other emp. Benefits		Royal Management Corp.	**	6,394	6,394	20
21	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,025	4,025	21
22	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	2,235	2,235	22
23	V	30	Depreciation - equipment		Royal Management Corp.	**	6,293	6,293	23
24	V	33	Property taxes		Royal Management Corp.	**	1,565	1,565	24
25	V	6	Repairs & maintenance		Royal Management Corp.	**	1,289	1,289	25
26	V	26	Insurance - general		Royal Management Corp.	**	1,808	1,808	26
27	V	6	Scavenger & exterminating		Royal Management Corp.	**	583	583	27
28	V	5	Utilities - gas & electric		Royal Management Corp.	**	1,900	1,900	28
29	V	5	Utilities - water & sewer		Royal Management Corp.	**	375	375	29
30	V	11	Activities Consultant		Royal Management Corp.	**	17	17	30
31	V	35	Equipment rental		Royal Management Corp.	**	385	385	31
32	V	20	Advertising - help wanted		Royal Management Corp.	**	3,725	3,725	32
33	V	25	Auto expense		Royal Management Corp.	**	8,852	8,852	33
34	V	21	Bank charges		Royal Management Corp.	**	280	280	34
35	V	19	Computer consultant & supplies		Royal Management Corp.	**	5,478	5,478	35
36	V	20	Dues & subscriptions		Royal Management Corp.	**	589	589	36
37	V	21	Office supplies & printing		Royal Management Corp.	**	7,108	7,108	37
38	V	21	Postage		Royal Management Corp.	**	2,653	2,653	38
39	Total			$			$ 94,081	$ * 94,081	39

** Certain owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Royal Management Corp.	**	$ 1,282	$ 1,282	15
16	V	6	Security service		Royal Management Corp.	**	13	13	16
17	V	21	Telephone		Royal Management Corp.	**	7,588	7,588	17
18	V	21	Communications		Royal Management Corp.	**	545	545	18
19	V	24	Travel & seminar		Royal Management Corp.	**	735	735	19
20	V	32	Interest		Royal Management Corp.	**	2,068	2,068	20
21	V	23	Training & education		Royal Management Corp.	**	282	282	21
22	V	17	Management fees	410,289	Royal Management Corp.	**		(410,289)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 410,289			$ 12,513	$ * (397,776)	39

** Certain owners of Lexington Health Care Center of Schaumburg, Inc. own 100% of Royal Management Corp.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	22.33%	See Schedule C	5	10.00%	Salary	$ 28,057	L 17, C 1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	22.33%	See Schedule C	2	4.00%	Salary	12,470	L 17, C 1	2
3	Cynthia Thiem	Owner/officer	Administrative	22.34%	See Schedule C	2	5.00%	Salary	15,587	L 17, C 1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	2	4.00%	Salary	4,988	L 17, C 1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	4	10.00%	Salary	8,291	L 17, C 1	5
6											6
7						All individuals work in excess of 40 hours per week.					7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 69,393		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	FICA	Bed Days	788,945	11	$ 232,594	$	81,984	$ 24,170	1
2	22	FUTA	Bed Days	788,945	11	4,830		81,984	502	2
3	22	SUTA	Bed Days	788,945	11	12,967		81,984	1,347	3
4	22	Insurance - W/C	Bed Days	788,945	11	2,735		81,984	284	4
5	22	Insurance - Hospitalization	Bed Days	788,945	11	117,633		81,984	12,224	5
6	22	401 (k) and other emp. Benefits	Bed Days	788,945	11	61,535		81,984	6,394	6
7	30	Depreciation - vehicles	Bed Days	788,945	11	38,735		81,984	4,025	7
8	30	Depreciation - leasehold improv.	Bed Days	788,945	11	21,505		81,984	2,235	8
9	30	Depreciation - equipment	Bed Days	788,945	11	60,561		81,984	6,293	9
10	33	Real estate taxes	Bed Days	788,945	11	15,061		81,984	1,565	10
11	6	Repairs & maintenance	Bed Days	788,945	11	12,408		81,984	1,289	11
12	26	Insurance - general	Bed Days	788,945	11	17,396		81,984	1,808	12
13	6	Scavenger & exterminating	Bed Days	788,945	11	5,608		81,984	583	13
14	5	Utilities - gas & electric	Bed Days	788,945	11	18,291		81,984	1,900	14
15	5	Utilities - water & sewer	Bed Days	788,945	11	3,608		81,984	375	15
16	11	Activity consultant	Bed Days	788,945	11	167		81,984	17	16
17	35	Equipment rental	Bed Days	788,945	11	3,709		81,984	385	17
18	20	Advertising - help wanted	Bed Days	788,945	11	35,848		81,984	3,725	18
19	25	Auto expense	Bed Days	788,945	11	85,184		81,984	8,852	19
20	21	Bank charges	Bed Days	788,945	11	2,695		81,984	280	20
21	19	Computer consultant & supplies	Bed Days	788,945	11	52,718		81,984	5,478	21
22	20	Dues & subscriptions	Bed Days	788,945	11	5,668		81,984	589	22
23	21	Office supplies & printing	Bed Days	788,945	11	68,404		81,984	7,108	23
24	21	Postage	Bed Days	788,945	11	25,535		81,984	2,653	24
25	TOTALS					$ 905,395	$		$ 94,081	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management
Street Address: 1300 S. Main Street
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 495-1700
Fax Number: (630) 495-4424

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed Days	788,945	11	$ 12,334	$	81,984	$ 1,282	1
2	6	Security Service	Bed Days	788,945	11	127		81,984	13	2
3	21	Telephone	Bed Days	788,945	11	73,022		81,984	7,588	3
4	21	Communications	Bed Days	788,945	11	5,248		81,984	545	4
5	24	Travel & seminar	Bed Days	788,945	11	7,077		81,984	735	5
6	32	Interest	Bed Days	788,945	11	19,899		81,984	2,068	6
7	23	Training & Education	Bed Days	788,945	11	2,716		81,984	282	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 120,423	$		$ 12,513	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Reilly Mortgage Group, Inc.		x	Mortgage	$55,967.00	02/01/91	$ 6,298,600	$ 6,120,818	02/01/31	0.1050	$ 644,027	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$55,967.00		$ 6,298,600	$ 6,120,818			$ 644,027	9
	B. Non-Facility Related*											
10								Amortization of loan costs			17,076	10
11								Interest income offset			(41,474)	11
12								Allocated from management company			2,068	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (22,330)	14
15	TOTALS (line 9+line14)						$ 6,298,600	$ 6,120,818			$ 621,697	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 415,000	1
	Allocated from management co.	1,565	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 393,271	2
3. Under or (over) accrual (line 2 minus line 1).		$ (20,164)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 413,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 7,625	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 400,461	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	381,033	8
	1996	391,413	9
	1997	397,180	10
	1998	395,337	11
	1999	393,271	12

1999 taxes:	393,271
Estimated increase (5%):	1.05
Estimated 2000 taxes:	412,935
Use:	413,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 85,541 B. General Construction Type: Exterior Concrete Block Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	230,000	1988	$ 211,532	1
2					2
3	TOTALS	230,000		$ 211,532	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	215		1990	1990	$ 5,865,346	$	35	$ 167,581	$ 167,581	$ 1,848,669	4
5	9		1995	1995	146,217	4,178	35	4,178		22,980	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1991	3,521	352	10	352		3,344	9
10	Building improvements			1992	859	25	35	25		209	10
11	Land improvements			1992	5,764		20	288	288	2,448	11
12	Land improvements			1992	5,000		20	250	250	1,875	12
13	Building improvements			1993	12,368		10	1,237	1,237	9,276	13
14	Fan coil units in offices			1996	5,149	147	35	147		662	14
15	Basement rehab			1997	14,697	1,470	10	1,470		5,634	15
16	Brick			1997	1,500	43	35	43		147	16
17	Dining room rehab			1997	6,422	642	10	642		2,140	17
18	Parking lot repave and restripe			1998	2,777	277	10	277		695	18
19	Wiring			1998	3,667	367	10	367		917	19
20	Retile 2nd and 3rd floor cooridors			1998	10,100	1,010	10	1,010		2,525	20
21	Plumbing for HVAC			1998	2,263	453	5	453		1,132	21
22	Lobby-floor tile			1999	7,478	748	10	748		1,371	22
23	Wallpaper-labor			1999	9,705	970	10	970		1,698	23
24	New patio			1999	19,039	1,269	15	1,269		1,586	24
25	New pay phone/wiring			1999	2,975	298	10	298		372	25
26	Repave and restripe parking lot			2000	10,735	537	10	537		537	26
27	Roof repairs			2000	9,625	481	10	481		481	27
28	Water heater			2000	6,669	334	10	334		334	28
29	Automatic door			2000	1,300	65	10	65		65	29
30	Rehab project - paint resident rooms, carpet hallways, and tile			2000	52,760	2,638	10	2,638		2,638	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 6,205,936	$ 16,304		$ 185,660	$ 169,356	$ 1,911,735	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from management company			1995	10,578		35	327	327	1,662	9
10	Allocated from management company			1996	8,608		35	266	266	1,107	10
11	Allocated from management company			1989	297		31	9	9	121	11
12	Allocated from management company - HVAC			1998	223		35	7	7	19	12
13	Allocated from management company - Offices			1999	562		35	17	17	24	13
14	Allocated from management company - Offices			2000	267		35	8	8	6	14
15	Allocated from management company			1987	49,448		31	1,531	1,531	20,086	15
16	Allocated from management company			1993	26		39	1	1	5	16
17	Allocated from management company			1995	1,114		39	34	34	156	17
18	Allocated from management company			1996	223		39	7	7	25	18
19	Allocated from management company - Sidewalk			1998	466		39	14	14	28	19
20	Allocated from management company - Roof			1998	17		15	1	1	4	20
21	Allocated from management company - Awnings			1999	288		39	9	9	42	21
22	Allocated from management company - Parking lot			1999	131		15	4	4	5	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 72,248	$		$ 2,235	$ 2,235	$ 23,290	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 580,939	$ 26,542	$ 35,904	$ 9,362	5-10	$ 461,557	37
38	Current Year Purchases	7,692	770	770		5	770	38
39	Fully Depreciated Assets	110,026				5-10	110,026	39
40	Allocated from Management Company	62,003		6,293	6,293		43,878	40
41	TOTALS	$ 760,660	$ 27,312	$ 42,967	$ 15,655		$ 616,231	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45	Allocated from Management Company			26,863		4,025	4,025		16,509	45
46	TOTALS			$ 26,863	$	$ 4,025	$ 4,025		$ 16,509	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 7,277,239	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 43,616	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 234,887	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 191,271	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,567,765	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Installation of water heaters	$ 12,102	58
59			59
60			60
61		$ 12,102	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,716 Description: Copier - $1,331; Allocated from Management Company - $385
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [x] NO
   It is the policy of this facility to only hire certified nurses aides.
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 3	hrs	$	10,438	$ 137,376	$	10,438	$ 137,376	1
2	Licensed Speech and Language Development Therapist	L 10A, C 3	hrs		2,608	27,842		2,608	27,842	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10A, C 3	hrs		29,843	294,234		29,843	294,234	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C 2	# of prescrpts				109,573		109,573	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Oxygen / Laboratory Other (specify): Clinitron beds	L 39, C 3 L 39, C 3				10,022 10,103			10,022 10,103	13
14	TOTAL			$	42,889	$ 479,577	$ 109,573	42,889	$ 589,150	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 95,352	$ 446,874	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 599,828)	1,814,751	1,814,751	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	25,439	35,156	6
7	Other Prepaid Expenses	411	411	7
8	Accounts Receivable (owners or related parties)	42,331	42,331	8
9	Other(specify): Deferred r/e/t appeal fees		7,625	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,978,284	$ 2,347,148	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		211,532	13
14	Buildings, at Historical Cost		5,865,346	14
15	Leasehold Improvements, at Historical Cost	329,560	412,838	15
16	Equipment, at Historical Cost	234,152	787,523	16
17	Accumulated Depreciation (book methods)	(161,030)	(2,567,765)	17
18	Deferred Charges		1,428	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): Escrow		584,089	22
23	Other(specify): See attached Schedule D		524,455	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 402,682	$ 5,819,446	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,380,966	$ 8,166,594	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 261,630	$ 269,255	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	169,566	169,566	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,436	2,436	31
32	Accrued Real Estate Taxes(Sch.IX-B)		413,000	32
33	Accrued Interest Payable		53,557	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule D	245,267	99,375	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 678,899	$ 1,007,189	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		6,120,818	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,120,818	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 678,899	$ 7,128,007	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,702,067	$ 1,038,587	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,380,966	$ 8,166,594	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,836,934	1
2	Restatements (describe):		2
3	**Prior year post closing entries**	(285,407)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,551,527	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,365,540	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,215,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 150,540	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,702,067	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,117,988	1
2	Discounts and Allowances for all Levels	(810,947)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 9,307,041	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	790,798	6
7	Oxygen	2,884	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 793,682	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	19,866	12
13	Barber and Beauty Care	33,622	13
14	Non-Patient Meals	643	14
15	Telephone, Television and Radio	122	15
16	Rental of Facility Space		16
17	Sale of Drugs	153,266	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,148	19
20	Radiology and X-Ray		20
21	Other Medical Services	137,545	21
22	Laundry	4,731	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 360,943	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,800	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,800	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached Schedule D	77,510	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 77,510	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,558,976	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,406,344	31
32	Health Care	4,082,041	32
33	General Administration	1,691,756	33
	B. Capital Expense		
34	Ownership	1,639,396	34
	C. Ancillary Expense		
35	Special Cost Centers	250,923	35
36	Provider Participation Fee	122,976	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,193,436	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,365,540	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,365,540	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,065	2,113	$ 61,379	$ 29.05	1
2	Assistant Director of Nursing	3,047	3,186	77,143	24.21	2
3	Registered Nurses	55,502	59,665	1,327,888	22.26	3
4	Licensed Practical Nurses	12,309	12,962	261,101	20.14	4
5	Nurse Aides & Orderlies	96,100	100,324	1,178,579	11.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,329	8,817	109,352	12.40	8
9	Activity Director	1,881	2,274	32,123	14.13	9
10	Activity Assistants	17,499	18,040	151,720	8.41	10
11	Social Service Workers	3,201	3,470	43,943	12.66	11
12	Dietician	205	219	4,458	20.36	12
13	Food Service Supervisor	2,086	2,086	27,814	13.33	13
14	Head Cook	1,990	2,086	24,496	11.74	14
15	Cook Helpers/Assistants	14,208	15,058	130,152	8.64	15
16	Dishwashers	16,979	17,775	114,033	6.42	16
17	Maintenance Workers	4,474	4,774	76,768	16.08	17
18	Housekeepers	40,031	42,079	271,985	6.46	18
19	Laundry	8,365	8,580	51,413	5.99	19
20	Administrator	1,936	2,097	80,448	38.36	20
21	Assistant Administrator					21
22	Other Administrative	674	691	69,393	100.42	22
23	Office Manager					23
24	Clerical	20,370	21,738	341,608	15.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	311,251	328,034	$ 4,435,796 *	$ 13.52	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 14,049	L 1, C 3	35
36	Medical Director	Monthly	9,000	L 9, C 3	36
37	Medical Records Consultant	19	950	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L 10, C 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	3,450	L 11, C 3	44
45	Social Service Consultant	Monthly	2,741	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	19	$ 31,390		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	7,826	97,824	L 10, C 3	52
53	TOTAL (lines 50 - 52)	7,826	$ 97,824		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Vicki Anderson	Administrator	0.00%	$ 80,448
John Samatas	Admin/Plant Ops	22.33%	12,470
James Samatas	Administrative	22.33%	28,057
Cynthia Thiem	Administrative	22.34%	15,587
George Samatas	Administrative	0.00%	4,988
Jason Samatas	Administrative	0.00%	8,291
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 149,841

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 410,289
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 410,289

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Bus. Svs.	Accounting	$ 7,700
Altschuler, Melvoin & Glasser LLP	Accounting	25,986
Aetna Life Insurance & Annuity	401(k) administration	915
Commitment Consulting	Collections	3,150
Freedman, Anselmo & Lindberg	Collections	18,868
Holleb & Coff	Legal	6,458
Personnel Planners	U/C Consulting	1,081
James Samatas	Legal	50
Sachnoff & Weaver	Legal	9,050
Royal Management Corp.	Web site development	338
Christine Toolan	Management Consulting	60
See attached Schedule E		11,297
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 84,953

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 48,340
Unemployment Compensation Insurance	21,230
FICA Taxes	327,111
Employee Health Insurance	122,360
Employee Meals	12,205
Illinois Municipal Retirement Fund (IMRF)*	
401(k) Contributions	32,140
Employee Transportation	39,618
Other Employee Benefits	10,888
TOTAL (agree to Schedule V, line 22, col.8)	$ 613,892

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	44,162
Health Care Worker Background Check	
(Indicate # of checks performed 60)	720
Miscellaneous Licenses & Permits	937
Miscellaneous Dues & Subscriptions	370
Allocated from Management Company	4,314
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 50,703

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,167
Allocated from Management Company	735
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,902

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lexington of Schaumburg # 0036095 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & decorating	1997	$ 1,911	3 yrs	$ 319	$ 637	$ 637	$ 318	$	$	$	$	$
2	Painting & decorating	Various 1998	3,991	3 yrs		665	1,330	1,330	666				
3	Painting & decorating	Oct-99	1,524	3 yrs			254	508	508	254			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
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16													
17													
18													
19													
20	TOTALS		$ 7,426		$ 319	$ 1,302	$ 2,221	$ 2,156	$ 1,174	$ 254	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Schaumburg **#** 0036095 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **77,667** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **122,976**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,205** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **643**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records are maintained**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.